

Indiana State Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012582 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED 01/26/2016 |
| NAME OF PROVIDER OR SUPPLIER PARK PLACE II, LLC | | STREET ADDRESS, CITY, STATE, ZIP CODE 4411 PARK PLACE DR FORT WAYNE, IN 46845 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
| R 000 | <p>INITIAL COMMENTS</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: January 25 & 26, 2016</p> <p>Facility number: 012582 Provider number: 012582 AIM number: N/A</p> <p>Census bed type: Residential: 138 Total: 138</p> <p>Census payor type: Medicaid: 32 Other: 106 Total: 138</p> <p>Sample: 6</p> <p>Park Place II, LCC was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p> <p>QR was completed by 99993 on 01/28/16.</p> | R 000 | | |

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE